Payer's Guide to Healthcare Diagnostic and Procedural Data Quality

2001 Edition

By the Coding Policy and Strategy Committee

AHIMA
AMERICAN HEALTH INFORMATION® MANAGEMENT ASSOCIATION

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Foreword

Background

The *Payer's Guide to Healthcare Diagnostic and Procedural Data Quality* has been prepared by the American Health Information Management Association's Coding Policy and Strategy Committee to facilitate a transition to uniform coding practices.

American Health Information Management Association

The American Health Information Management Association (AHIMA) represents more than 40,000 health information management and health record professionals. Health information management professionals ensure that patient health information is accurate, meets complex legal, licensure and accreditation standards, and is accessible to healthcare providers, institutional administrators, and insurance companies. This information forms the basis of patient-care, financial, and utilization decisions throughout the healthcare industry. AHIMA advocates quality healthcare data and its transformation into meaningful healthcare information to improve the effectiveness and quality of patient care. Members of AHIMA are united in their belief that the quality of patient care today and tomorrow is dependent on the quality of health information.

Coding Policy and Strategy Committee

AHIMA's Coding Policy and Strategy Committee functions under the direction of AHIMA and is composed of several volunteers appointed by AHIMA’s president. The committee is responsible for tracking and analyzing implications of vocabulary and classification system development, advising staff on strategies for influencing major users of coded data and legislation, regulations, standards, and policies impacting the quality of coded data, and advising staff on strategies for the introduction and implementation of ICD-10 and any other potential coding systems. The committee is also charged with maintaining a strong leadership position with respect to coding issues.

AHIMA Leadership

Employer groups, consumers, managed care organizations, payers, and regulating and accrediting agencies request, collect, and analyze healthcare data for numerous reasons. What are their concerns about the quality of healthcare data? How does the quality of this data impact what they do? What are future data needs? Are credentialed health information management professionals (RHIAs, RHITs, CCSs, and CCS-Ps), who understand the current and future impact of the data demands on the healthcare marketplace, involved in analysis, review, and interpretation of the data? If not, who is doing this work and what are their credentials and skills?

Why Was This Payer's Guide Developed?

The *Payer's Guide* was developed for the following purposes:

- To educate the payer community about the national coding guidelines and their relationship to national data quality and comparability
- To highlight how the inconsistent application of coding guidelines is eroding the quality of healthcare data
- To illustrate the relationship between the quality of coded data and healthcare costs, reimbursement, and outcomes
- To encourage the payer community to examine their policies and revise those that are inconsistent with national coding guidelines

To facilitate immediate improvement in the quality of coded healthcare data, we ask you to consider these four critical recommendations:

1. Consider overall data quality and nationally accepted coding guidelines in the application of payment structures to coded data
2. Accept appropriate alphanumeric codes, such as V codes, as principal diagnoses to ensure consistent and accurate application of codes
3. Adopt new diagnostic and procedure codes at the time they are enacted, to ensure complete and comparable data
4. Utilize qualified staff for assessment of the validity of coded data

How to Use This Guide

The *Payer's Guide to Healthcare Data Quality and Integrity* was assembled to introduce you to the issues of data quality and to serve as a helpful resource. This guide is designed to help build a bridge between the payer community and the health information management professionals in your area.

The *Payer's Guide* is divided into eight major sections:

- **ICD-9-CM Maintenance and Guideline Development:** This section provides an overview of the structure and process of ICD-9-CM creation and maintenance. It also includes key contacts for obtaining more information, or offering suggestions about ICD-9-CM.
- **ICD-10-CM and ICD-10-PCS:** This section discusses the future implementation of ICD-10-CM and ICD-10-PCS as a replacement for ICD-9-CM, the advantages of adopting these new systems, some of the significant differences between these systems and ICD-9-CM, and the changes that the healthcare industry will need to make in preparation for implementation of these systems.
- **CPT Development and Maintenance:** This section provides an overview of *Current Procedural Terminology* (CPT), a description of CPT resources, contact information for services, and answers to questions.
- **Health Information Management:** This section describes the health information management profession, educational opportunities and professional certification. This section also includes a description of coder certification and how to obtain more information about this program.
- **Coding Audits:** This section explains the auditing and monitoring processes providers have implemented to ensure the accuracy of the codes reported on claims and the necessary qualifications for coding auditors.
- **Official ICD-9-CM Guidelines for Coding and Reporting:** The current complete guidelines are provided in this section.

- **Issues in the Industry:** AHIMA position statements and resolutions define the key issues in data quality. A collection of articles that point to the failures of current databases, the growing need for improved data quality, and the recommended collaborative approach are included in this section to highlight the broader issues of data quality.
- **Other Resources:** Catalogues and samples of coding resources are included to provide ongoing opportunities for staying current.

Introduction

Accurate and complete coded data must be available in all healthcare settings to improve the quality and effectiveness of patient care, to ensure equitable healthcare reimbursement, and to permit valid research and analytical studies of aggregate coded data. The need has never been greater for a national cooperative effort to recognize and apply uniform terminology and coding guidelines. The American Health Information Management Association's Coding Policy and Strategy Committee has developed this guide to convey the importance of consistent and reliable data collection and reporting practices and to aid third party payers in collecting and reporting coded data. This guide provides information on the coding guidelines and describes how these guidelines are developed and maintained.

Background

In the United States, diagnostic and procedural information is coded using nationally accepted standardized classification systems. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is used for inpatient and ambulatory diagnoses and for the inpatient procedure coding. Current Procedural Terminology, Fourth Edition (CPT) is used for ambulatory procedure coding.

The Uniform Hospital Discharge Data Set (UHDDS) supplies definitions of the core data elements collected on acute inpatient hospitalizations. This data set includes definitions of principal diagnoses, reportable secondary diagnoses, and procedures. It was developed to specify standard definitions that facilitate collection of uniform and comparable health information from all hospitals. UHDDS must be used for Medicare and Medicaid reporting. Many other payers also require use of UHDDS.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of standards for code sets for data elements that are part of all healthcare transactions. HIPAA defines code sets as "any set of codes used to encode data elements." The code sets which affect HIM professionals are those related to diagnosis, procedure, equipment, and supply coding. HIPAA directs the use of ICD-9-CM Volumes I & II for the coding of all

diagnoses (in any setting: hospital, ambulatory care centers, physician offices, and on.). ICD-9-CM Volume III should be used for coding all inpatient procedures. All ambulatory and physician services should use a combination of CPT-4 and HCPCS. HCPCS will apply to other substances, equipment, supplies, and other items used in healthcare services. Since each of these code sets are updated annually (ICD-9-CM is updated October 1, while CPT-4/HCPCS is updated January 1), the version that is valid at the time healthcare services are furnished must be used. Both healthcare plans and providers must maintain up-to-date code sets for each system. This requires annual updating of all software/encoder programs, purchase of annual updates or new code books, and modification of computer systems to accept the current code set version based on date of service provided.

HIPAA does not require insurers to pay all valid ICD-9-CM, CPT-4, and HCPCS codes but they do require acceptance of them and adherence to the "Official ICD-9-CM Guidelines for Coding and Reporting." The Official Coding Guidelines are published in the American Hospital Association's quarterly newsletter, *Coding Clinic for ICD-9-CM*, and can also be downloaded from this Web site: http://www.cdc.gov/nchs/data/icdguide.pdf. These guidelines are considered "official" because all guidelines and directives contained in this newsletter are endorsed by the Cooperating Parties. The following organizations comprise the Cooperating Parties:

- Healthcare Financing Administration (HCFA)
- American Hospital Association (AHA)
- American Health Information Management Association (AHIMA)
- National Center for Health Statistics (NCHS)

A copy of the Official ICD-9-CM Guidelines for Coding and Reporting can be found in section six.

HIPAA requires the elimination of all local HCPCS Level III codes that have been established. HIPAA allows a two-year transition for health plans and providers to the standard code sets specified in the final rule. This will mean all steps necessary for adoption of this requirement must be completed for implementation by October 2002. The standardization of code sets will decrease costs and reduce administrative burdens associated with the use of multiple, duplicative code sets and versions of code sets.

The standard code sets named in the HIPAA regulations regarding electronic transactions follow:

- ICD-9-CM, Volumes 1 and 2, which is maintained by the National Center for Health Statistics and HCFA, is to be used to report diseases, injuries, impairments, and other health problems and their manifestations
- ICD-9-CM, Volume 3, which is maintained by HCFA, is to be used by hospitals to report procedures or other actions taken on inpatients to prevent, diagnose, treat, and manage diseases, injuries, and impairments
- CDT (Current Dental Terminology), which is maintained by the American Dental Association, is to be used for reporting dental services
- NDC (National Drug Codes), which are maintained and distributed by the United States Food and Drug Administration, in collaboration with drug manufacturers, are to be used to report drugs and biologics

- HCPCS (Healthcare Financing Administration's Common Procedural Coding System), a combination of Level 1 (CPT), which is maintained by the American Medical Association, and Level 2 codes, which is maintained by HCFA, Blue Cross/Blue Shield Association of America, and the Health Insurance Association of America, are to be reported for physician and other healthcare services and all other substances, equipment, supplies, or other items used in healthcare services. These items include medical supplies, orthotic and prosthetic devices, and durable medical equipment.

Benefits of Accurately Coded Data

Because decisions will only be as good as the coded information on which they are based, providers and payers must work together to ensure consistency and accuracy in the coding process. Accurate and complete coded data allows payers to successfully attain the following:

- Uniform reimbursement levels
- Track provider resource utilization patterns
- Monitor patient outcomes
- Analyze quality of patient care
- Develop future healthcare policies
- Monitor healthcare fraud and abuse issues
- Establish benchmarking data to maintain a competitive edge in the healthcare marketplace
- Write coverage policies and contractual agreements

Furthermore, compliance with the official coding guidelines presented in this publication may help with the following:

- Reducing administrative costs associated with the appeal process
- Responding to compliance issues related to sections of HIPAA legislation
- Improving relations with both patients and providers

Payers are responsible for up-front screening of claims under HIPAA. Since the code sets are used to pay the provider for services rendered, to gather information across the country for comparison in many different contexts, and to provide a means for all healthcare entities to submit consistent and complete data, it is important that data integrity is maintained. In order to assure that providers are submitting consistent and complete data everyone should follow the rules that have been established. The four Cooperating Parties, Healthcare Financing Administration, the National Center for Health Statistics, the American Hospital Association, and the American Health Information Management Association are responsible for establishing the official coding guidelines for ICD-9-CM. The American Medical Association establishes the official rules for proper use of CPT. These guidelines are the basis for establishing any healthcare fraud and abuse. Under the HIPAA, "...any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should have known is applicable to the item or service actually

provided," can be subjected to civil and criminal penalties when engaging in this type of practice. This sort of healthcare fraud can result in a provider being fined $10,000 for each instance and/or imprisonment for not more than ten years. Though HIPAA is a federal act there are a number of states that have enacted similar legislation to prevent healthcare fraud on a statewide basis. A payer violates the act anytime the payer directs a healthcare entity to submit a claim with codes that violate the official coding guidelines.

Aside from HIPAA, there are a number of other reasons a payer would benefit from accurate and complete coding. Coded clinical information is used for the assessment of the quality of patient care, outcomes analysis, financial management, strategic planning, evaluation of utilization trends, analysis of practice patterns, formulation of health policy decisions, and justification for healthcare costs and reimbursement. Coded data provide key information for shaping current and future healthcare policy. Reliance on healthcare databases that contain inconsistencies and local interpretations poses the question of bias in coding toward reimbursement and creates the potential for incomplete and incorrect coded data. Without quality coded healthcare data, the appropriate planning and responsible resource allocation required for future healthcare in the United States will not take place.

Interest in medical outcomes is expanding rapidly. The use of claims databases for measuring outcomes of medical and surgical practice and outcomes for patients with chronic illness are being evaluated in current studies. As Derek C. Angus wrote, "Databases have been criticized when used for research because of reliability concerns, especially with regard to coding practice...All administrative databases are subject to inconsistency in coding between institutions, diseases, and patients" (JAMA, 276, no. 33 [October 2, 1996]: 1080–1081). How can healthcare be compared or measured if the data collection methods are not the same and if they are influenced by reimbursement issues? The National Committee for Quality Assurance staes that "it is our goal to provide standardized specification that minimize the need for judgment calls, which, when made by individual health plans, could erode the potential for comparability over the long term...The data collection methodology used can have an impact on performance rates " (Guidelines for Data Reporting, HEDIS 2.5: January 1996).

The advantages of accurately coded data enhance the payer's ability to collect valid coded data and use that data to ease contract negotiations, in the development of coverage policies, and to compile actuarial benefits. The HIPAA regulation pertaining to standards for electronic transactions allows for the sharing of healthcare data across the healthcare industry, thus requiring the need for data integrity. Additionally, if all payers utilize the official coding rules and require complete and accurate submission of claims, the reliability of data across the healthcare industry will improve considerably. From an administrative standpoint, improved quality of coded data reduces the cost of administering the healthcare program. The consistency resulting from utilizing a standard code set and using the official coding rules improves customer relationships by reducing confrontations with members regarding the payer's non-payment of claims. Claims processing efficiencies and decreased costs will occur because adherence to the same set of coding rules by both payers and providers results in fewer claims denials and appeals. Additionally, comparisons with competitors can be effectively achieved.

Utilizing the appropriate code set according to the rules established by the organization responsible for maintenance of the code set can eliminate the variances in data integrity that involve code descriptions in computer systems that sometimes don't match those in the official version of the coding system, decrease the number of truncated codes, and provide the opportunity to compare codes using the same version of published code sets.

Barriers to Accurately Coded Data

Accurately coded data offers the users of the data many benefits. However, there are various obstacles to achieving quality in coded data. Following are typical barriers to accurately coded data.

Various Coding Systems

Today, many different coding systems are used to report services. If a patient is covered by more than one health plan, the same encounter may have to be coded using more than one coding system, depending on the different payers' requirements. Each system has its own unique set of rules, directions and guidelines. Because of the demands of reporting data with multiple coding systems, data accuracy and completeness may be difficult to ensure. The implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA) will alleviate the current problems with multiple coding system requirements, as these regulations stipulate the standard code sets that are to be used.

Failure to recognize updated codes

Updates to the ICD-9-CM coding system are effective on October 1 of each year. Updates to CPT are effective every year on January 1. When updated codes are not accepted, a payer runs the risk of rejecting many legitimate claims.

Multitude of Payers

Because a healthcare provider must work with many payers, the process of submitting data is very involved and complicated. When each payer has unique rules and directives, the potential for inaccurate reporting increases. As an example, one payer may expect that the CPT modifier –52 be appended to the colonoscopy code when reporting an incomplete colonoscopy. Others may require the provider to assign a code that reports the extent of the procedure actually performed, such as a sigmoidoscopy.

Truncating Codes

The process of truncating codes develops a database of questionable value. For example, the diagnosis of diabetes mellitus is reported with information as to whether the patient is insulin-dependent (IDDM) or non-insulin dependent (NIDDM). In this instance, the appropriate ICD-9-CM codes are 250.00: diabetes mellitus without mention of complication, NIDDM; and 250.01: diabetes mellitus without mention of complication, IDDM. If the payer uses only the first three digits (250), valuable data describing the disease is lost.

Failure to Apply UHDDS Guidelines

If UHDDS guidelines are ignored, valuable data may be reported inaccurately. Several studies have concluded that the selection of diagnosis and procedure codes reported by healthcare providers are driven by the reimbursement process and not UHDDS definitions. Thus the process for code selection, code sequencing and uniform application of official coding rules, conventions, and the guidelines may often vary across hospital and by payer source (Table 1).

Failure to Apply Established Coding Guidelines

If the coding guidelines developed by the four Cooperating Parties (NCHS, HCFA, AHA, and AHIMA) are ignored, serious damage may be done to the accuracy of the database. See Table 1 for examples of individual payer requirements that violate coding guidelines and result in data of poor quality.

Payment Issues

The practice of "changing the codes to get the bill paid" has become a threat to the integrity of healthcare databases. For example, consider an outpatient record that documents the reason for an encounter to be "change of an arm cast." Some payers may correctly apply coding guidelines and accept code V54.8 (Other orthopedic aftercare). Other payers may reject the claim and require that the encounter be re-coded as an acute fracture, using a code such as 818.0 (Closed fracture of upper limb). Professional coders receive extensive training that allows them to accurately select codes based on the documentation contained in the medical record. Professional coders recognize that it is inappropriate to re-code the encounter in order to obtain payment.

Failure to Recognize Differences in Reporting Inpatient and Ambulatory Visits

Inpatient admissions and ambulatory visits have their own unique coding guidelines. For example, inconclusive diagnoses qualified with such terms as "probable", "suspected", "questionable," or "rule out" are coded as if they exist in the inpatient setting. However, in the outpatient setting, only the code that identifies the condition known to the highest degree of certainty is to be reported. This may include a symptom or an abnormal test result code. A review of the Official ICD-9-CM Guidelines for Coding and Reporting in section six, provides the specifications for reporting hospital-based and physician office outpatient services.

Failure to Require "Reason for Visit" Information

Although the Admitting Diagnosis field on the UB-92 has been approved to capture the reason for visit on emergent/urgent outpatient encounters, payers are not consistently requiring that this information be reported. For example, when a patient presents to the emergency room with complaints of chest pain and the physician determines that the definitive diagnosis is gastritis, the ICD-9-CM code for chest pain should be entered in the Admitting Diagnosis field. By not taking advantage of this coded data, payers are ignoring a valuable tool to help in the analysis of healthcare information.

Failure to Stay Abreast of Official Coding Advice

Official coding advice and instructions are offered quarterly in AHA's *Coding Clinic for ICD-9-CM* and monthly in the American Medical Association's *CPT Assistant*. Payers should be aware of the advice offered in these publications. For example, *Coding Clinic* First Quarter 2000 updates outpatient coding practices to allow the reporting of diagnoses made by radiologists or pathologists. Because of this coding clarification, payers may see an increase in reported diagnoses such as pneumonia and a decrease in the reporting of symptom codes such as cough.

Conclusion

Accurate and complete coded data can be achieved if all payers and healthcare providers use standardized, uniform processes of collecting data. Tables 1 and 2 offer examples of how the incorrect application of ICD-9-CM and CPT coding guidelines can damage the quality of coded data.

The rest of the *Payer's Guide* provides other information on guidelines and related topics:

- ICD-9-CM maintenance and guideline development process
- International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) and ICD-10-Procedural Coding System (ICD-10-PCS)
- CPT development and maintenance process
- Professional credentials offered by the American Health Information Management Association (AHIMA)
- Coding audit processes put in place by providers
- Official ICD-9-CM Guidelines for Coding and Reporting
- AHIMA's Standards of Ethical Coding
- AHIMA position statements and practice briefs pertaining to coding and classification issues
- Reprinted articles from the *Journal of the American Health Information Management Association* of interest to anyone who is responsible for quality coded data in their organization

Table 1 Examples of Payer Coding Instructions That Decrease the Quality of Aggregate Data: ICD-9-CM Examples

Code in Question	Correct Use of Code	Payer Explanation/Instruction	Impact on Data
V04.5 Prophylaxis for rabies	For a person who encounters the health system for the purpose of receiving an inoculation to prevent rabies	Will not accept V04.5. Hospitals must incorrectly use a code for "late effect" in order to receive payment for services	The true reason for the healthcare encounter is lost and the reason for services is misrepresented
V51.x–V58.x Aftercare visit codes (except V56.x, V58.0, V58.1)	Aftercare visit codes are listed first when the initial treatment of a disease or injury has been completed but the patient requires continued care during recovery	For postacute care admissions, assign the code for the acute condition instead of the appropriate late effect or aftercare code	Visits for the purpose of recovery care or follow-up care are classified the same way as acute conditions or injuries, so the reason for services is not captured correctly and the incidence of encounters for treatment of the acute condition is misrepresented
V53.09 Patient is admitted for refilling of a baclofen pump used for pain management Payer will not accept V53.09 for filling or adjustment of device related to nervous system	Description of the event is filling of the device, not actual treatment of the patient's debilitating condition	Payer will only pay for the visit if the patient's chronic condition is coded.	Information is lost on the actual reasons for health services
V57.x Care involving rehabilitation procedures	A code from category V57 is assigned as the principal diagnosis when the patient is admitted for the purpose of rehabilitation following previous illness or injury	Assign the code for the original injury or illness that led to the disability or the residual condition requiring rehabilitation	The reason for services is not captured correctly and the status of the illness or injury is misrepresented
V58.1 Encounter for chemotherapy	V58.1 is sequenced first when the encounter or admission is for the purpose of receiving chemotherapy	Requires sequencing the malignancy as the principal diagnosis and the V58.1 as a secondary code	The reason for the encounter is not captured correctly
V76.2 Pap smear with V72.6 laboratory examination	Code for a Pap smear is V76.2	Requires use of V76.2 with V72.6	This code combination implies that two exams may have been performed
V72.8x Other specified examinations	Code is used for preoperative testing and examinations, usually done on an outpatient basis Medicare requires specific medical or surgical condition to validate medical necessity	V72.8 may not be sequenced as principal diagnosis; expect reason for surgery to be coded as the principal diagnosis Code V70.0 for a general medical exam is accepted instead of V72.8	Database will not recognize the encounter as a pre-op visit and assumption will be made that surgical diagnosis is reason for the test Medicare supposedly follows *Coding Clinic* guidelines but does not follow this rule.
Use of all V codes is discouraged by payers	V codes reflect patients' reasons for services, including aftercare, therapy, and follow-up	Report an acute condition in order to be paid	Accurate information about the true reasons for healthcare services is lost.
290-319 Codes within the Mental Health Chapter of ICD-9-CM are not accepted from a provider who is not a psychiatrist or psychologist	ICD-9-CM codes are not restricted to be used by a particular branch of medicine or specialized practitioner	Codes from the mental health chapter are returned to the provider or deleted from the claim by the payer	The full extent of a patient's health may not be known if certain codes are deleted from an encounter

Table 1 Examples of Payer Coding Instructions That Decrease the Quality of Aggregate Data: ICD-9-CM Examples (Continued)

Code in Question	Correct Use of Code	Payer Explanation./Instruction	Impact on Data
Category 315 codes Specific delays in development	To specify development dyslexia, reading disorders and other learning difficulties	Codes in this category are not accepted and are rejected as uncovered mental health services	Statistics on treatment of delayed development not due to intellectual retardation or inadequate schooling will be lost
410.x2 Acute myocardial infarction, subsequent episode of care	ICD-9-CM instructions require use of fifth digit 1 for "initial episode of care" for a newly diagnosed MI "1" is correctly used regardless of the number of times a patient is transferred	May not use a "1" on the second hospital's claim for a patient transferred during the acute episode of care Hospitals are required to use a "2" which conflicts with coding guidelines	The data generated by the incorrect use of the episode of care fifth digit will affect assessment of length of stay and appropriateness of services
493.9x Asthma and 786.05 Shortness of breath	If asthma is determined to be the cause of the shortness of breath, it must be coded instead of the symptom	To code the symptom of shortness of breath instead of the definitive diagnosis	Data will not reflect the physician's diagnosis established after evaluation of the patient's symptoms
562.13 Diverticulitis of colon with hemorrhage 578.9 GI Bleeding	When patient is evaluated to determine cause of GI bleeding, the definite diagnosis should be coded instead of the symptom	Presenting symptoms are required to be coded instead of the final diagnosis established during the encounter	Data will not reflect the physician's diagnosis established after evaluation of the patient's symptoms
585 Chronic renal failure 403 Hypertensive renal disease 404 Hypertensive Heart and Renal Disease	When a patient has both a renal disease and hypertension, either category 403 or 404 should be assigned with the appropriate fifth digit to indicate renal failure	Use code 585 for all patients receiving dialysis, even if the patient's diagnosis is hypertensive renal disease	Data will not accurately reflect the relationship between hypertension and chronic renal failure
Code 659.8x Other specified indications for care or intervention related to labor and delivery Code is not allowed when the patient does not have the conditions listed in the inclusionary statement with this code	Code 659.8 is intended to describe conditions other than those specified in the codes 659.0-659.7 Conditions listed under 659.8 are pregnancy in a female less than 16 years old at expected date of delivery or very young maternal age	Payer does accept code 659.9 which the providers begin to use to describe "other specific" conditions	Information is lost because the unspecified code is used more frequently than is necessary
650-677 and V30 Payer requires both the maternal and newborn codes to appear on the same claim when both are discharged on the same day If the baby stays longer, the newborn codes can be submitted on a separate claim	Maternal codes are valid on maternal record Neonatal codes are valid on newborn record	Payer will not pay for newborn services unless newborn codes appear on maternal claim	Internal and external systems will conflict when the provider has to move newborn codes onto the maternal record for billing yet leaves the newborn claims on the newborn account for internal purposes
764 and 765 Slow fetal growth and fetal malnutrition and disorders relating to short gestation and unspecified low birth weight	To report low birth weights, immaturity and malnutrition	Do not use these codes unless the infant stays beyond the average length of stay	Data on the number of premature and immature infants that do not require an extended length of stay will be lost

(continued on following page)

Table 1 Examples of Payer Coding Instructions That Decrease the Quality of Aggregate Data: ICD-9-CM Examples (Continued)

Code in Question	Correct Use of Code	Payer Explanation/Instruction	Impact on Data
740-759 Congenital Anomaly Codes such as those for anencephalus, spina bifida and other anomalies of specific organs	To identify the presence of various abnormalities present on birth	Codes are not allowed unless the total length of stay exceeds the average	The true number of infants or children treated who have congenital anomalies will be lost
State Birth Defect Registry defines a list of conditions that must be reported as secondary diagnoses for newborns	Birth defect codes meet the definition of additional diagnoses for newborns	Payer using a defunct DRG system for Medicaid (New Jersey) wants the code deleted if it qualifies as a "CC" if the condition was not treated or did not extend the length of stay	Inconsistent reporting of birth defects by providers; some maintain two databases – one for registry and one for payment Others accept lower DRG payment but refuse to remove the code from their internal database
760-779 Perinatal section or the Congenital Anomalies section (740-759) of ICD-9-CM are not accepted for patients over the age of 1 month or 1 year	These codes are not restricted according to the age of the patient but instead reflect the origin of the condition	Codes from these two sections are edited out or returned to the provider or deleted from the claim by the payer	Information is lost on important long term conditions that originated at birth or early in life
Category 496 COPD 250.xx Diabetes, 428.x CHF, 401.x Hypertension, 332.x Parkinsonism	Chronic conditions that affect patient care are reportable in accordance with the UHDDS definition of "other diagnoses"	Unless chronic conditions are uncontrolled or there is an acute exacerbation, they are not accepted even if the condition is evaluated, monitored and treated during the course of care	Information is lost on important chronic illnesses which affect overall patient health status and clinical outcomes
Chronic condition codes, such as COPD, CHF, Emphysema, Arthritis, Hypertension, not accepted when active treatment is not given	Chronic conditions that affect patient care are reportable in accordance with the UHDDS definition of "other diagnoses" *Coding Clinic* has acknowledged the coding of such conditions is correct	Unless chronic conditions are actively treated or evaluated, they are not accepted. According to the payer the diagnosis must "affect the treatment received and/or the LOS." Also the code cannot be used to qualify as a "CC" for a DRG or DRG-like payment system	Even when the physician or anesthesiologist documents that condition exists, the information is lost because the code is deleted by the payer, thus information is lost on important chronic illnesses which affect overall patient health status and clinical outcomes
Only five diagnosis codes are accepted by the payer instead of the nine spaces included on the UB92	Nine spaces are available on the UB92 for principal and additional diagnosis codes	Report principal and all major CCs in the five spaces	Complete information about the patient's condition is lost when all of the diagnoses are not accepted.
Symptom codes required with acute condition to justify medical necessity or to justify use of the emergency department	Signs and symptoms are not coded when the cause of the problems are identified	Code the acute sign or symptom to explain why the patient required urgent or emergent medical care; for example, fever due to otitis media; wheezing due to asthma	Over-coding occurs with unnecessary information included in the database It is difficult to determine retrospectively if the symptom was related or unrelated to the other disease listed.

Table 1 Examples of Payer Coding Instructions That Decrease the Quality of Aggregate Data: ICD-9-CM Examples (Continued)

Code in Question	Correct Use of Code	Payer Explanation/Instruction	Impact on Data
51.22 Total Cholecystectomy 54.21 Laparoscopy	Code 51.23 is now available for laparoscopic cholecystectomy	Incorrectly require both codes to describe a lap cholecystectomy	The incorrect use of this code combination after a specific code was developed for a lap cholecystectomy skews the data for open cholecystectomy
73.59 ICD-9-CM procedure code for assisted delivery is required as principal on all deliveries	Definition of principal procedure is not followed (For example, if patient had a third degree laceration repair, it would have to be listed as a secondary procedure)	Payer requires 73.59 as principal for all obstetrical deliveries	The actual principal procedure cannot be identified because it could be any one of the additional procedures listed
72.0- 75.99 ICD-9-CM obstetrical procedure codes trigger payment for a “surgical procedure” instead of paying for the obstetrical global package	ICD-9-CM obstetrical procedure codes are not intended to delete the fact that the patient received an entire obstetrical service	Payer instructs provider not to report obstetrical surgical service (for example, laceration repairs, if they want obstetrical global fee paid)	Procedures performed at the time of delivery are not known

Table 2 Examples of Payer Coding Instructions That Decrease the Quality of Aggregate Data: CPT Examples

Code in Question	Correct Use of Code	Payer Explanation/ Instruction	Impact on Data
49310 – 49311 Lap Cholecystectomy	These codes were deleted from CPT in 1994	Use the deleted codes in order to have a claim paid	The ability to correctly aggregate data on laparoscopic procedures may be compromised
12001 – 13160 Repair of skin (closure of wounds) 15100-15121 Tissue Cultured Grafts	Skin repairs include use of sutures, staples or tissue adhesives Codes for grafts include tissue-cultured skin grafts	Payers instruct providers to use G0168 for tissue adhesives and G0170 and G0171 for tissue cultured skin grafts	The HCPCS G codes for the procedures will not be retained in databases or available for provider analysis, nor will data be comparable between encounters using CPT codes and those using HCPCS codes
No unlisted CPT code is accepted	Unlisted CPT codes intended to reflect new procedures for which a current CPT code is not available	Payer requires the provider to submit a CPT code that is the "best available" to describe the procedure	The incidence of new procedures cannot be tracked Certain procedures appear to be performed more frequently than is actually the case
85102 CPT code for bone marrow biopsy is not accepted when charges for an operating room are included	There is no other CPT code for bone marrow biopsy	Report a "bone biopsy" code (20220-20245) instead of laboratory chapter code (85102) for an operative procedure or when revenue code 360 is used	Information about the actual procedure is lost Over-reporting of other procedures occurs
No codes exist for alternative medicine procedures provided by practitioners	No codes exist for massage by non-physical therapy staff or many other services	Use physical therapy codes when benefits exist for alternative medicine procedures	Gives the appearance that more physical therapy was performed than actually occurred. Even in the absence of third party payment, providers are unable to track the occurrence of certain procedures except through the use of their own internal coding system
Correct Coding Initiative (CCI) edits applied inconsistently or older versions of the CCI edits are used	One set of CCI edits are intended to be in effect during a particular quarter	Payer selects which CCI edits it prefers. Payer chooses to maintain one version of the CCI edits throughout the year instead of updating per quarter.	Provider may choose not to report certain CPT codes knowing the codes will be edited out. Incomplete reporting of actual procedures exists
Payer creates their own internal "correct coding edits" but may not publish	Payer rules should be made available to the provider	Payer may only identify its edits on the explanation of benefits returned with the payment No appeal mechanism exists	Provider may choose not to report certain CPT codes once the payers edits are known in order to produce a "clean claim" and actual services are not reported

Table 2 Examples of Payer Coding Instructions That Decrease the Quality of Aggregate Data: CPT Examples (Continued)

Code in Question	Correct Use of Code	Payer Explanation/ Instruction	Impact on Data
Payer creates their own definition of "simple" or "complex" (e.g., 10080-10081)	CPT does not include definitions of all codes but leaves the code selection to the discretion of the physician/provider	Payer may only identify its edits on the explanation of benefits returned with the payment Payer definitions are only available "verbally" but not in writing No appeal mechanism exists.	Provider may choose to report their services according to the payer's definition instead of what actually occurred in order to produce a "clean claim" and obtain payment quickly
Payer creates its own definition of CPT modifiers	Standard set of modifier definitions included in CPT book for both physicians and facilities	Payer may only define modifier if asked No written materials available	Provider does not how to apply modifiers to claims Information is lost on what was performed
Payer continues to require CPT codes deleted in current version of book	Only codes included in the current version of the CPT book are considered valid	Payer returns claims with "new" codes stating it will only process the claim with the "old" codes	Internal and external systems will conflict and accurate reporting of services is lost
Payer changes HCPCS/modifier codes on the submitted claim that it believes reflects the services provided	Clinical coding is based on clinical documentation, not financial or claims information	Change codes in the interest of its beneficiaries	Codes may be inaccurate because documentation is not required to make the code change

International Classification of Disease Ninth Revision—Clinical Modification

The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) is a modification of the *International Classification of Diseases, Ninth Revision* (ICD-9) developed by the World Health Organization (WHO).

The *International Classification of Diseases* (ICD) is a classification system that originated in the late nineteenth century as the International List of Causes of Death. Its purpose was to standardize reporting of causes of death throughout the world. ICD has been updated periodically to reflect changes in medical technology and provide greater specificity in classifying diagnoses and causes of injury. The most recent edition of the ICD is ICD-10. This system has not yet been implemented in the United States for morbidity reporting.

In the United States, ICD has been modified and expanded to reflect more precisely the nonfatal conditions for which people will enter the healthcare system. This includes conditions for which they will be hospitalized, or for those treated in ambulatory settings by physicians and other medical care providers. Today, ICD is used for classification of morbidity data, indexing of patient records, medical care review, basic health statistics, and research.

In 1979, ICD-9-CM became the single classification system used for inpatient morbidity reporting in the United States. In the United States today, patient diagnoses are described according to this system. All procedures performed on hospitalized patients are coded according to the procedure classification of ICD-9-CM, as well as many non-Medicare procedures performed in ambulatory settings within a hospital.

ICD-9-CM is updated annually to reflect changes in technology and knowledge of disease processes and to provide a more precise system for describing the clinical picture of the patient. Furthermore, there is an organized method for continuing review of all coding rules and guidelines to provide accurate, consistent reporting of coded data throughout the United States.

System Modifications, Updates, and Revisions

The ICD-9-CM Coordination and Maintenance Committee is a federal interdepartmental committee charged with the mission of maintaining and updating ICD-9-CM. That mission includes approving coding changes and developing errata, addenda, and other modifications to ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The committee is also responsible for promoting the use of federal and non-federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the system.

The ICD-9-CM Coordination and Maintenance Committee, which meets two times each year, is co-chaired by the Healthcare Financing Administration (HCFA) and the National Center for Health Statistics (NCHS). NCHS has lead responsibility for the ICD-9-CM diagnosis codes included in volume 1, Diseases: Tabular List, and volume 2, Diseases: Alphabetic Index, while HCFA has lead responsibility for the ICD9-CM procedure codes included in volume 3, Procedures: Tabular List and Alphabetic Index.

The Coordination and Maintenance Committee process ensures stability of the classification system and its comparability with its parent system, ICD-9. No official changes are made without this committee's approval and all changes to the ICD-9-CM are shared with the WHO to ensure continued comparability with ICD-9. Suggestions for modifications come from both the public and private sectors. Recommendations for modifications are submitted in writing prior to a scheduled meeting. The meetings are announced in the Federal Register and are open to the public. Summaries of the meetings are disseminated to more than 600 individuals and/or organizations.

The ICD-9-CM Coordination and Maintenance Committee's role is advisory. All final decisions are made after the December meeting with the joint approval of the administrator of HCFA and the director of NCHS and become effective October 1 of the following year. New codes and code extensions are published in the Federal Register. Official code revision packages, referred to as addenda, are published each year prior to the October 1 effective date by the American Hospital Association (AHA) in its newsletter *Coding Clinic for ICD-9-CM*. Modifications to the alphabetic index and revisions of notes are found only in the addenda.

ICD-9-CM Resources and Services

Coding Clinic for ICD-9-CM is a quarterly newsletter published by AHA's Central Office on ICD-9-CM to facilitate greater dissemination of clearinghouse information to hospitals and other involved parties on the use of ICD-9-CM and uniform data sets for reporting purposes. Its major functions follow:

- To provide ICD-9-CM coding advice and official guidelines relative to uses for hospital-based inpatient and outpatient coding, physician-based coding, as well as internal and external reporting needs of hospitals
- To answer questions on code assignments and sequencing of codes
- To serve as an important, current reference on regulatory and other requirements for reporting diagnostic and procedural information from patient health records

- To present topics and articles that provide practical information, improve technical skills in coding, and address issues facing health information management professionals on the various uses of ICD-9-CM, data reporting requirements, data edits, health record documentation and authentication, and other related matters

Coding Clinic for ICD-9-CM is the only private newsletter recognized as the official source for approved coding guidelines and advice. Official coding guidelines are developed and approved by the Cooperating Parties (see page 10).

All material drafted for publication in *Coding Clinic* is reviewed by the *Coding Clinic* Editorial Advisory Board (EAB). The EAB includes representatives of the Cooperating Parties, nosologists, the American Medical Association, the American College of Physicians, the American College of Surgeons, and other experts in medical classification and health information management.

To maintain nationwide coding consistency, it is important that only one official source exists for coders with coding questions. In the early 1960s, AHA established the Central Office on ICD-9-CM. The Central Office receives inquiries from physicians, professional review organizations, and hospital coders regarding ICD-9-CM classification assignments. In instances in which new coding assignments are requested or there is evidence of an error or oversight in ICD-9-CM code assignment, the Central Office staff responds by asking for further information, consulting medical text references, and/or assisting in drafting more specific recommendations. These issues are then referred to the *Coding Clinic* EAB for their consideration. If the EAB determines that no existing code is applicable, the issue is referred to the ICD-9-CM Coordination and Maintenance Committee for consideration of a new code.

Coding and Data Quality

Achieving nationwide excellence in coding is a goal of AHIMA. Many of the coding issues brought to the EAB for consideration are from AHIMA members. AHIMA's dedication to coding and data quality can be seen through its ongoing efforts to conduct quality educational programs on coding and to publish instructional materials on coding in various settings as well as *Journal of AHIMA* updates to keep members informed on today's coding issues.

The ICD-9-CM codes are the basis for HCFA's Medicare reimbursement and program evaluation. Accurate coding is emphasized by HCFA, whose representatives participate on the EAB, to assure consistent application of the classification by all parties.

ICD-9-CM Resources

Requests for ICD-9-CM coding advice should be directed to:

Nelly Leon-Chisen, RHIA
Director, Central Office on ICD-9-CM
American Hospital Association
1 N. Franklin
Chicago, IL 60606

Phone: (312) 422-3366
Subscription to *Coding Clinic*: (800) 261-6246
Web site: http://www.icd-9-cm.org

Requests for ICD-9-CM diagnosis code revisions should be directed to:

Donna Pickett, MPH, RHIA
Medical Classification Administrator
National Center for Health Statistics
Office of Planning and Extramural Programs
6525 Belcrest Rd., Room 1100
Hyattsville, MD 20782

Phone: (301) 458-4434
Fax: (301) 458-4022
Email: dfp4@cdc.gov

Requests for ICD-9-CM procedure code revisions should be directed to:

Patricia Brooks, RHIA
Technical Assistant, Office of Hospital Policy
Division of Prospective Payment System
Healthcare Financing Administration
Mail Stop C4-07-07
7500 Security Blvd.
Baltimore, MD 21244-1850

Phone: (410) 786-5318
Fax: (410) 786-0169
Email: pbrooks@hcfa.gov

Questions or input concerning coding or classification issues or guidelines may be directed to:

Sue Prophet, RHIA, CCS
Director, Coding Policy and Compliance
American Health Information Management Association
233 N. Michigan Ave.
Suite 2150
Chicago, IL 60601-5800

Phone: (312) 233-1115
Fax: (312) 233-1090
Email: sue.prophet@ahima.org

The Official ICD-9-CM Guidelines for Coding and Reporting can be downloaded from http://www.cdcgov/nchs/data/icdguide.pd

ICD-10-CM and ICD-10-PCS

ICD-10 was developed by the World Health Organization as a replacement for ICD-9 and is already being used in a number of countries. ICD-10-CM is a clinical modification of ICD-10 developed by the National Center for Health Statistics for use in the United States as a replacement for the ICD-9-CM diagnosis codes. ICD-10-CM was developed following a thorough evaluation by a Technical Advisory Panel and extensive additional consultation with physician groups, clinical coders, and others to assure clinical accuracy and utility. It is believed that ICD-10-CM is a significant improvement over ICD-9-CM. Notable improvements include the addition of codes relevant to ambulatory and managed care encounters, expanded injury codes, and the addition of laterality. Greater specificity and clinical detail were incorporated in order to provide information for clinical decision-making and outcomes research. The structure of ICD-10-CM will allow greater expansion than was possible with ICD-9-CM. The system is entirely alphanumeric (all codes begin with a letter) and a sixth digit was incorporated.

Effective January 1, 1999, the World Health Organization's ICD-10 was implemented for mortality reporting (the coding of death certificates) in the United States

The ICD-9-CM procedure codes have been used in the United States since 1979. The structure of this procedural coding system has not allowed new procedures associated with rapidly-changing technology to be effectively incorporated as new codes. Like its predecessor, ICD-9, ICD-10 does not include a procedural classification. The Healthcare Financing Administration, which is the agency responsible for maintenance of the ICD-9-CM procedure codes, contracted with 3M Health Information Systems to develop a replacement system for the ICD-9-CM procedure codes. The objectives of the new system were to improve the accuracy and efficiency of coding, reduce training efforts, and improve communication with physicians. The outcome was ICD-10-PCS. This system is based on a seven-character, alphanumeric code using the digits 0-9 and the letters A–H, J–N, and P–Z. This system has been found to contain much greater specificity and detail than the ICD-9-CM procedural classification, and is easier to expand. It is thought that this system will lead to improved accuracy and efficiency of coding.

ICD-9-CM (both the diagnostic and procedural components) is no longer able to meet the many needs for accurate and complete data in this country. Accurate and complete coded data is necessary for the following purposes:

- To improve the quality and effectiveness of patient care
- To ensure equitable healthcare reimbursement
- To facilitate public health tracking

- To expand the body of medical knowledge
- To make appropriate decisions regarding healthcare policies, delivery systems, funding, expansion, and education
- To monitor resource utilization
- To improve clinical decision-making
- To permit valid clinical research, epidemiological studies, outcomes and statistical analyses, provider profiling, and analytical studies of aggregate coded data

Without quality coded healthcare data, the appropriate planning and responsible resource allocation required for the future of healthcare in the United State can not occur. ICD-9-CM was first implemented in 1979 and has become outdated and obsolete. Terminology used in ICD-9-CM and the classification of some conditions are outdated and inconsistent with current medical knowledge. A major area of weakness of ICD-9-CM is that it is not always precise or unambiguous. The system is already out of space and unable to accommodate new codes to address the need for greater specificity, advances in medicine, new diseases, and new medical technology. The ICD-9-CM Coordination and Maintenance Committee has already been faced with code proposals for new codes that were recommended for implementation but could not be added to ICD-9-CM simply because there was no space to create a new code. In the Proposed Rule, "Health Insurance Reform: Standards for Electronic Transactions" (published in the May 7, 1998 *Federal Register*), the Healthcare Financing Administration states that some of the recommended code sets lack a desirable level of flexibility and that steps should be taken to improve their flexibility or replace them with more flexible options sometime after the year 2000.

While many of the problems with ICD-9-CM can not be solved in ICD-9-CM, they are addressed in ICD-10-CM and ICD-10-PCS. ICD-10-CM and ICD-10-PCS incorporate much greater specificity and clinical detail, which will result in significant improvements in the quality of the data used for all of the purposes mentioned above. They can accommodate advances in medical knowledge and technology. Medical advances that have occurred between implementation of ICD-9-CM and today have been incorporated. ICD-9-CM code proposals that were recommended in the past but could not be implemented due to lack of space have been incorporated in ICD-10-CM.

When ICD-9-CM was implemented, most healthcare was provided in an inpatient setting. Therefore, ICD-9-CM does a very poor job of meeting ambulatory data needs. ICD-10-CM provides much better information for ambulatory and managed care encounters.

There is a significant expansion in ICD-10-CM of types of symptoms and the specificity of these systems. For example, just in the category of pain, there are codes for acute postoperative pain, acute pain in neoplastic disease, chronic intractable postoperative pain, and chronic intractable pain in neoplastic disease. In the "abnormalities of breathing" category, there are codes for orthopnea, shortness of breath, stridor, wheezing, periodic breathing, hyperventilation, mouth breathing, hiccough, and sneezing. Newly recognized conditions not uniquely identified in ICD-9-CM have unique codes in ICD-10-CM. Examples include coronary thrombosis not resulting in infarction and mild, moderate, and severe dysplasia. Conditions with a recently discovered etiology or new treatment protocol have been reassigned to a more appropriate chapter in ICD-10-CM. For example, gout is in the endocrine chapter in ICD-9-CM, but in the musculoskeletal chapter in ICD-10-CM. Refractory anemia is in the chapter for blood and blood-forming organs in ICD-9-CM, but in the neoplasm chapter in ICD-10-CM.

Laterality has been incorporated into ICD-10-CM. There is more specification as to the type and site of injuries. Postoperative complications have been expanded in ICD-10-CM and a distinction has been made between intraoperative complications and postprocedural disorders. Combination codes have been created for some conditions and symptoms or manifestations that commonly occur with these conditions. Creation of these combination codes will reduce the number of codes needed to fully describe a condition. For example, there are combination codes for pathological fractures and their underlying causes (such as neoplastic disease and osteoporosis).

These examples are only a sample of the many improvements incorporated into ICD-10-CM. In addition to the significant improvements in specificity and clinical detail in ICD-10-CM and ICD-10-PCS, both systems also allow future expansion to easily accommodate the need for new codes, medical advances, and new medical technology, so that these systems will remain useful well into the future.

There are significant resource implications in changing classification systems:

•Costs of new software and software upgrades for providers, payers, and data users

—Interfaces between computer systems

- Massive educational initiatives for coding professionals as well as the many users of coded data
- Complete re-structuring of existing coding educational programs
- Crosswalk development among coding systems to maintain comparability with historical data
- Complete re-structuring of all systems based on the ICD-9-CM classification system, such as:
- Prospective payment systems
- Payment policies
- Performance measurement systems
- Provider profiling systems
- Modifications of computer systems using ICD-9-CM codes (such as encoders, utilization review systems, clinical protocols or critical pathways, clinical reminder systems, and diagnostic test ordering systems)
- Electronic transactions
- Modification of policies, procedures and paper forms

Furthermore, changing classification systems may result in interruption of longitudinal data trends and may affect the comparability of longitudinal studies. There will be a need for a conversion system to cross-reference between pre-and post-crossover periods so that researchers can understand the new system and how it correlates to data already collected from the existing system. A database or tagged version of the new system that could facilitate mapping would need to be developed. It will be necessary to check the validity of new codes, data retrieval, and crosswalks. Transition validity checks will also be necessary.

However, there would be tremendous cost savings in greatly improved clinical data. For example, the greater level of specificity in ICD-10-CM and ICD-10-PCS will result in the availability of better information to support reimbursement (such as justification of medical necessity), which will mean an increased ability of payers to make informed decisions

regarding coverage and reimbursement and a reduced need for payers to request medical record documentation. Better data will permit payers to forecast the healthcare needs of their covered lives, trend and analyze healthcare costs, and analyze how their money is being spent. The availability of higher-quality data will result in significant reductions in both payers' and providers' costs due to improved analysis of patient outcomes and effectiveness of treatments, provider profiling, and development of clinical practice guidelines. Improved data will better be able to detect patterns of over-utilization and under-utilization, monitor outcomes, and detect fraud. Better data regarding reasons people seek healthcare and the treatments they receive will improve providers' and payers' ability to negotiate reimbursement terms (including managed care contracts) that reflect the actual costs of providing care. Improved terminology and more clarity and accuracy in the classification system will require more complete and accurate medical record documentation, which will ultimately result in improved patient care.

It is important to maintain data comparability with the rest of the world in order to conduct global research studies. Many other countries have already implemented ICD-10 and still others are planning to do so in the near future. It is also important to maintain comparability between United States mortality and morbidity data.

The Center for Health Policy Studies has already conducted a comprehensive evaluation of ICD-10 and concluded that a clinical modification of ICD-10 would be a significant improvement over ICD-9-CM and warranted adoption in the United States. In June 1997, the National Committee on Vital and Health Statistics recommended to the Secretary of Health and Human Services that the industry be advised to build and modify their information systems to accommodate a change to ICD-10-CM. In the HIPAA Proposed Rule regarding standards for electronic transactions, it states that changes in code sets will be required to address current coding system deficiencies that adversely affect the efficiency and quality of the creation of administrative data and to meet international treaty obligations. The Proposed Rule also recommends that in addition to accommodating the initial code set standards for the year 2000, those that produce and process electronic administrative health transactions should build the system flexibility that will allow them to implement different code formats beyond the year 2000.

The time frame for implementation of either ICD-10-CM or ICD-10-PCS is uncertain, as it is dependent on requirements stipulated by the Health Insurance Portability and Accountability Act (HIPAA). This legislation requires the establishment of national standards for electronic transmission of health data, which includes standards for diagnosis and procedure code sets. ICD-9-CM has been named as the initial standard for diagnoses and hospital inpatient procedures, and CPT and HCPCS have been named as the standard for physician services and other healthcare standards. Adoption of a new code set would require following a defined process, which includes promulgation of a new regulation, with the opportunity for public comment.

Current Procedural Terminology

The American Medical Association (AMA) works to promote quality and correct coding of healthcare services through its maintenance of *Physicians' Current Procedural Terminology* (CPT). CPT is an accurate, up-to-date, comprehensive listing of medical procedures and services identified by a five-digit code. This reporting system is used by nearly all physicians and healthcare professionals to simplify the reporting of services for reimbursement and data collection. CPT provides an objective, practice-based system for describing procedures and services and does not assign monetary values or medical opinions to any of the services.

History of CPT

The AMA first developed and published CPT in 1966. The first edition of CPT helped encourage the use of standard terms and descriptors to document procedures, helped to communicate accurate information to agencies concerned with insurance claims, and contributed basic information for actuarial and statistical purposes.

The second edition of CPT was published in 1970, and contained an expanded system of terms and codes. At that time, a five-digit coding system was introduced, replacing the former four digit classification.

In the mid- to late-1970s, the third and fourth editions of CPT were introduced. The fourth edition, published in 1977, represented significant updates in medical technology and periodic updating was introduced to keep up with the rapidly changing medical environment.

In 1983, CPT was adopted as part of the Healthcare Financing Administration's (HCFA's) Common Procedure Coding System (HCPCS), and mandated to report services under Part B of the Medicare Program. In October 1986, HCFA also required the use of HCPCS in the Medicaid system. In July 1987, as part of the Omnibus Budget Reconciliation Act, HCFA mandated the use of CPT for reporting outpatient hospital surgical procedures.

The AMA undertook an initiative known as the CPT-5 Project in 1998 in order to make improvements in the structure and processes of the CPT codes to better reflect the coding demands of the modern dynamic healthcare system. Objectives included enhancing the use of CPT by practicing physicians; making improvements to CPT that address the needs of non-physician healthcare professionals, other types of providers (such as hospitals, managed care organizations, and ambulatory and long-term care facilities), and researchers; and develop mechanisms to incorporate timely updates to CPT to reflect changing practice patterns and new technologies. As a result of this project, a number of enhancements will gradually be made to CPT. These changes include improved code descriptors, new sections for performance

measurement codes and tracking codes for new technology, development of CPT education initiatives; development of an enhanced Index, and development of a terminology glossary to standardize definitions and differentiate the use of synonymous terms. Tracking codes for new and emerging technology will be known as Category III codes and will be released semi-annually (twice a year, in January and July) via electronic distribution on the AMA/CPT Web site. The full set of Category III codes will be included in the next published edition for that CPT cycle. These codes will be assigned an alphanumeric identifier with a letter in the last field (e.g., 1234B). CPT-5 changes will be phased in gradually, and it is anticipated that they will be completed with the publication of CPT 2003.

Today, CPT is used extensively throughout the United States as the preferred system of coding and describing physicians' services.

System Modifications, Updates, and Revisions

CPT is updated on an annual basis. Each CPT code and descriptor is carefully reviewed and written to reflect the many diverse services provided by healthcare professionals. AMA's CPT Advisory Committee, with representatives from more than 80 national medical specialty societies, and the Healthcare Professional Advisory Committee comprised of allied health professionals (such as nurses, occupational therapists, and physical therapists) review all new code proposals to update CPT.

The CPT Editorial Panel is ultimately responsible for maintaining CPT. The CPT Editorial Panel consists of 16 physician members, four of which represent the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the Healthcare Financing Administration, and the American Hospital Association. AMA plans to add another physician member with expertise in managed care. The American Health Information Management Association and the American Hospital Association also participate in the panel's meetings and deliberations.

AMA's Department of Coding and Nomenclature maintains CPT, and provides all administrative support to the CPT process by working with the CPT Advisory Committee and the CPT Editorial Panel. AMA's Department of Coding and Nomenclature works cooperatively with AMA departments dedicated to Medicare's Resource-based Relative Value Scale and other payment policy issues. This department also develops products and resources to help communicate and educate about CPT.

CPT Resources and Services

AMA's Department of Coding and Nomenclature's health information specialists provide a valuable coding consultation service: CPT Information Services (CPT-IS). These specialists provide information and answers to specific questions about CPT codes. CPT-IS offers clarification and guidance on the interpretation of CPT codes directly from the AMA.

The Department of Coding and Nomenclature publishes a monthly newsletter, *CPT Assistant*, an award-winning resource for professionals who want regular technical coding support from AMA. Every issue offers practical tips, expert guidance and insight, and illustrated detailed case studies to help code more accurately. A question-and-answer section covers the questions that professional coders ask most often. *CPT Assistant* also provides information about the latest legislative issues and government initiatives on codes and how they affect the CPT use.

AMA's annual CPT Coding Symposium discusses upcoming CPT changes and attracts professionals from around the country who want to hear coding changes that will affect their practices. It is an excellent resource for learning the most up-to-date CPT information. Symposium attendees receive a course syllabus that outlines the coding changes, as well as a complimentary copy of CPT and *CPT Assistant* detailing the upcoming coding changes.

To facilitate and ensure that CPT reflects the most up-to-date listing of services and procedures, requests to add, revise, or delete CPT codes are encouraged and can be submitted by all interested individuals and parties, including physicians, insurance companies, allied health professionals, drug and device manufacturers, and coding professionals. To assist in submission of requests for revisions to CPT, Coding Change Request Forms and a CPT Process Brochure are available upon request from AMA.

Additionally, AMA's coding staff members actively work within the national healthcare community on a variety of projects, including speaking and training and committee participation.

To purchase CPT, *CPT Assistant* newsletter, and other coding references, or
to subscribe to CPT Information Services (CPT-IS), call:
AMA Customer Service
(800) 621-8335

AMA CPT Information Services (CPT-IS):
(800) 634-6922
(subscription packages are available)

Visit the AMA Web site (http://www.ama-assn.org) for information on the history, process, and maintenance of CPT, or to obtain a coding change request form to propose a code addition, revision, or deletion to CPT.

Information regarding the annual CPT Coding Symposium and on-line ordering of AMA products, such as *CPT Assistant*, can also be found on the AMA Web site. Additionally, newly-approved vaccine and Category III codes that are released on a biannual basis (January and July) are posted on the AMA Web site.

Coding and Data Quality

AMA promotes correct coding through its relationships with national medical specialty societies, allied healthcare and coding professionals, insurers, third party payers, and the Healthcare Financing Administration.

The CPT Editorial Panel is dedicated to improving data quality by developing accurate and correct codes and interpretations of appropriate applications of CPT. This is accomplished by several mechanisms and resources provided by AMA.

Through its articles, *CPT Assistant*, is an excellent source of clarification of appropriate CPT coding. CPT Information Services (CPT-IS) provides accurate coding advice and correct interpretation of CPT codes, as well. Also, AMA, through its Correct Coding Policy Committee, is actively pursuing avenues in which accurate coding can be communicated and preserved through CPT.

As AMA has developed and maintains the CPT classification system, it should be looked to as the principal resource for consistent interpretation of CPT codes and guidelines.

Health Information Management

The American Health Information Management Association (AHIMA) is the professional healthcare organization of more than 40,000 health information management (HIM) and health record professionals. HIM professionals ensure that patient information is accurate; meets complex legal, licensure and accreditation standards; and is accessible to healthcare providers, institutional administrators, and insurance companies. AHIMA is committed to the quality of health information for the benefit of patients, providers, and other users of clinical data. The association's duties include the following:

- To advance health information technologies and professional practice standards
- To advocate patient privacy rights and confidentiality of health information
- To influence public and private policies and educates the public regarding health information
- To provide leadership in HIM education and professional development

Society for Clinical Coding

The Society for Clinical Coding (SCC) is a membership organization affiliated with AHIMA, committed to advancing the quality of coded data, promoting coder education, and providing a forum for practitioners specializing in the coding of healthcare data. Membership is open to both members and nonmembers of AHIMA. Benefits of membership include a bimonthly newsletter, educational programs, participation in state coding roundtables, networking, and access to a forum for professional growth and development. SCC members include coders, quality assurance professionals, educators, consultants, physicians, and representatives of the insurance industry and government regulatory agencies.

For more information about AHIMA, SCC, the health information management profession, careers paths, or certification, contact:

American Health Information Management Association
233 N. Michigan Ave., Suite 2150
Chicago, IL 60601-5800

Phone: (312) 233-1100
Fax: (312) 233-1090
Web site: www.ahima.org
Product Orders Fax: (312) 233-1500
General E-mail: info@ahima.org

Health Information Management Credentials

Because of the unique combination of knowledge and skills possessed by HIM professionals, they are qualified for numerous positions within the healthcare and health insurance industries. Health information management combines knowledge of healthcare (from both the clinical and administrative perspectives) with knowledge of data collection and analysis, information systems, legal aspects of healthcare, and record management. Classification of diseases and procedures has been a component of HIM since the earliest days of the profession. A healthcare payer who hires or contracts with an HIM professional obtains the services of a person well-versed in coding and payment issues and also someone who understands how classification systems and their correct use affect the larger picture of healthcare.

Health information professionals may receive their education through an accredited program at one of more than 200 colleges and universities. Those who have completed the appropriate educational requirements may apply for certification as registered health information administrators (with a bachelor's degree) or registered health information technicians (with an associate degree).

The American Health Information Management Association (AHIMA) offers certification for health information professionals. The following information (excerpted from the AHIMA Web site) briefly summarizes four certifications available for health information managers and coding professionals.

Registered Health Information Administrator

The registered health information administrator certification (formerly registered record administrator [RRA]) requires a bachelor's degree and successful performance on the RHIA certification exam. RHIAs are skilled in the collection, interpretation, and analysis of patient data. Additionally, they receive the training necessary to assume managerial positions related to these functions. RHIAs interact with all levels of an organization--clinical, financial, administrative—that employ patient data in decision making and every day operations.

Registered Health Information Technician

The registered health information technician certification (formerly Accredited Record Technician [ART]) requires an associate's degree and successful performance on the RHIT certification exam. RHITs are health information technicians who ensure the quality of medical records by verifying their completeness, accuracy, and proper entry into computer systems.

They may also use computer applications to assemble and analyze patient data for the purpose of improving patient care or controlling costs. RHITs often specialize in coding diagnoses and procedures in patient records for reimbursement and research.

In addition to the RHIA and RHIT credentials, AHIMA offers two credentials for individuals with experience as medical coders.

Certified Coding Specialist

The Certified Coding Specialist (CCS) is a professional skilled in classifying medical data from patient records, generally in the hospital setting.

Certified Coding Specialist-Physician-based (CCS-P)

The Certified Coding Specialist—Physician-based (CCS-P) is a coding practitioner with expertise in physician-based settings such as physician offices, group practices, multi-specialty clinics, or specialty centers.

Both the CCS and CCS-P require a high school diploma and successful completion of the respective exam.

The American Health Information Management Association also provides resources that are useful in training coders and others with regard to many issues affecting coding and data quality. Among other topics, AHIMA products address CPT coding, ICD-9-CM coding, reimbursement, compliance, HIPAA, documentation guidelines, data quality management, and data security. Products include books, audio cassettes, Internet seminars, and other types of media.

More information about AHIMA’s certifications and a list of schools with accredited RHIA/RHIT programs can be obtained at the AHIMA Web site (http://www.ahima.org).

Coding Audits

In response to compliance guidelines established in the 1998 Office of Inspector General (OIG) Compliance Program Guidance for Hospitals, healthcare providers across the country have implemented ongoing coding audit programs utilizing both internal and external resources. Such audit programs may be concurrent so that errors or omissions are identified prior to claim submission. Software that prompts coders may be utilized by some organizations to edit the coding process and guide decision making for selection of codes in accordance with coding guidelines and payer rules. Formal audits based on review of a sample of coded records are also conducted retrospectively, either internally or by an auditing firm with expertise in coding and reimbursement methodologies.

Formal audits involve selection of a random or stratified sample of medical records. The records are audited and recoded to ensure that the coding was performed accurately. Coding accuracy encompasses assignment of proper codes, appropriate code sequencing and identification of all reportable diagnoses and procedures in accordance with Official Coding Guidelines published by the AHA in *Coding Clinic*. The scope of the review, frequency of reviews and size of the sample depend on the size of the organization, the number of coders and identified problem areas. Auditing and monitoring processes should encompass claims submitted to private payers and government programs alike.

For DRG based reviews, cases may be selected in a variety of ways:

- Simple random sample
- High dollar and high volume DRGs
- DRGs without comorbid conditions or complications
- Focused DRGs such as DRG 79 Pneumonia or DRG 416 Septicemia and other high risk DRGs under review by the state PROs or those identified in OIG investigations Work Plans
- Correct designation of patient discharge and transfer status

For private, commercial and managed-care inpatient cases, the audit may be structured to address the following:

- Specific types of cases covered by contract (for example, maternity or specific types of surgery)
- High volume diagnoses or procedures

- High dollar claims
- Cases with low margins or returns
- High denial rates
- Unpaid claims

For physician services, hospital outpatient services, and freestanding ambulatory surgery centers, audits may focus on the following:

- Evaluation and management services for physician visits
- High volume and/or low volume outpatient surgeries
- Use of CPT modifiers on physician and outpatient claims
- Unlisted CPT codes
- Use of "separate" procedure codes
- Diagnosis codes on outpatient claims for medical necessity of diagnostic services
- Accurate use of ICD-9-CM and CPT for ambulatory surgery services

Findings from auditing and monitoring activities should be documented and feedback presented to appropriate individuals, including coding staff and physicians. Action plans should be established to improve accuracy, change processes and practices, and further monitoring must be done to demonstrate improvement.

An important aspect in establishing an ongoing coding program is determining who will perform the audits. Providers must decide whether they have adequately trained coding professionals on staff who can objectively perform regular auditing of coding. Payers who wish to implement ongoing audit programs must also determine who will perform the reviews. Determining the accuracy of submitted codes requires specialized knowledge and skill in proper coding and the medical record review process. Extensive training is required in order to code correctly and to have the skills and competencies necessary to assess coding accuracy. Acquisition of the basic core skill set in coding requires approximately a year of course work and then several years of experience in order to become a proficient expert coding professional.

AHIMA recommends that all payers implementing a coding audit program should hire or contract with credentialed HIM professionals to perform reviews of diagnostic and procedural coding accuracy. The payer can be more confident about the validity of the findings if HIM professionals, who are specifically trained in coding principles, are utilized to perform the reviews. HIM professionals who specialize in coding must have a thorough understanding of the content of the medical record in order to be able to locate information to support or provide specificity for coding. They must also be highly trained in the anatomy and physiology of the human body, disease processes and pharmacology in order to understand the etiology, pathology, symptoms, signs, diagnostic studies, treatment modalities and prognosis of diseases and procedures to be coded. Coding professionals must also be thoroughly knowledgeable in, and able to apply the coding rules and conventions for multiple coding systems and the official coding guidelines.

AHIMA issues four credentials which are reviewed in section four of the *Payer's Guide*. The clinical coding specialist (CCS) and clinical coding specialist – physician-based (CCS-P) provide specialist certifications in the coding field.

Official ICD-9-CM Guidelines for Coding and Reporting

The Public Health Service and the Healthcare Financing Administration of the United States Department of Health and Human Services present the following guidelines for coding and reporting using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). These guidelines should be used as a companion document to the official versions of the ICD-9-CM.

These guidelines for coding and reporting have been developed and approved by the cooperating parties for ICD-9-CM: American Hospital Association, American Health Information Management Association, Healthcare Financing Administration, and the National Center for Health Statistics. These guidelines previously appeared in the *Coding Clinic for ICD-9-CM*, published by the American Hospital Association.

These guidelines have been developed to assist the user in coding and reporting in situations where the ICD-9-CM manuals do not provide direction. Coding and sequencing instructions in the three ICD-9-CM manuals take precedence over any guidelines.

These guidelines are not exhaustive. The cooperating parties are continuing to conduct review of these guidelines and develop new guidelines as needed. Users of the ICD-9-CM should be aware that only guidelines approved by the cooperating parties are official. Revision of these guidelines and new guidelines will be published by the United States Department of Health and Human Services when they are approved by the cooperating parties.

Official Guidelines for Coding and Reporting

The following is a table of contents for the official ICD-9-CM guidelines for coding and reporting. After this list, the actual guidelines follow.

1. General Inpatient Coding Guidelines

1.1 Use of Both Alphabetic Index and Tabular List

A. Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.
B. Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

1.2 Level of Specificity in Coding

Diagnostic and procedure codes are to be used at their highest level of specificity:

- Assign three-digit codes only if there are no four-digit codes within that code category
- Assign four-digit codes only if there is no fifth-digit subclassification for that category
- Assign the fifth-digit subclassification code for those categories where it exists

1.3 Other (NEC) and Unspecified (NOS) Code Titles

Codes labeled "other specified" (NEC not elsewhere classified) or "unspecified" (NOS not otherwise specified) are used only when neither the diagnostic statement nor a thorough review of the medical record provides adequate information to permit assignment of a more specific code.

Use the code assignment for "other" or NEC when the information at hand specifies a condition but no separate code for that condition is provided. Use "unspecified" (NOS) when the information at hand does not permit either a more specific or "other" code assignment.

When the Alphabetic Index assigns a code to a category labeled "other (NEC)" or to a category labeled "unspecified (NOS)," refer to the Tabular List and review the titles and

inclusion terms in the subdivisions under that particular three-digit category (or subdivision under the four-digit code) to determine if the information at hand can be appropriately assigned to a more specific code.

1.4 Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

1.5 Combination Code

A single code used to classify two diagnoses or a diagnosis with an associated secondary process (manifestation) or an associated complication is called a combination code. Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code may be used as a secondary code.

1.6 Multiple Coding of Diagnoses

Multiple coding is required for certain conditions not subject to the rules for combination codes.

Instruction for conditions that require multiple coding appear in the Alphabetic Index and the Tabular List.

A. Alphabetic Index: Codes for both etiology and manifestation of a disease appear following the subentry term, with the second code in brackets. Assign both codes in the same sequence in which they appear in the Alphabetic Index.

B. Tabular List: Instructional terms, such as "Code first...," "Use additional code for any...," and "Note...," indicate when to use more than one code.
"Code first underlying disease"—Assign the codes for both the manifestation and underlying cause. The codes for manifestations cannot be used (designated) as principal diagnosis.
"Use additional code, to identify manifestation, as ..."—Assign also the code that identifies the manifestation, such as, but not limited to, the examples listed. The codes for manifestations cannot be used (designated) as principal diagnosis.

C. Apply multiple coding instructions throughout the classification where appropriate, whether or not multiple coding directions appear in the Alphabetic Index or the Tabular List. Avoid indiscriminate multiple coding or irrelevant information, such as symptoms or signs characteristic of the diagnosis.

1.7 Late Effect

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury.

Coding of late effects requires two codes:

- The residual condition or nature of the late effect
- The cause of the late effect

The residual condition or nature of the late effect is sequenced first, followed by the cause of the late effect, except in those few instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title or the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s).

The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the cause of the late effect.

A. Late Effects of Cerebrovascular Disease: Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to 430–437. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the conditon classifiable to 430-437.

Codes from category 438 may be assigned on a healthcare record with codes from 430-437, if the patient has a current CVA and deficitsd from an old CVA.

Assign code V12.59 (and not code 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

1.8 Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approaches that correspond most closely with the established diagnosis.

1.9 Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

- If it did occur, code as confirmed diagnosis
- If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "impending" and for "threatened"
- If the subterms are listed, assign the given code

- If the subterms are not listed, code the existing forerunner condition(s) and not the condition described as impending or threatened

2. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

In determining principal diagnosis the coding directives in the ICD-9-CM manuals, Volumes 1, 2, and 3, take precedence over all other guidelines.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

2.1 Codes for Symptoms, Signs, and Ill-defined Conditions

Codes for symptoms, signs, and ill-defined conditions from chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

2.2 Codes in Brackets

Codes in brackets in the Alphabetic Index can never be sequenced as principal diagnosis. Coding directives require that the codes in brackets be sequenced in the order as they appear in the Alphabetic Index.

2.3 Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

2.4 Two or More Interrelated Conditions, Each Potentially Meeting the Definition for Principal Diagnosis

When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

2.5 Two or More Diagnoses That Equally Meet the Definition for Principal Diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

2.6 Two or More Comparative or Contrasting Conditions

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

2.7 Symptom(s) Followed by Contrasting/Comparative Diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as suspected conditions.

2.8 Codes from the V71.0–V71.9 Series, Observation and Evaluation for Suspected Conditions

Codes from the V71.0–V71.9 series are assigned as principal diagnoses for encounters or admissions to evaluate the patient's condition when there is some evidence to suggest the existence of an abnormal condition or following an accident or other incident that ordinarily results in a health problem, and where no supporting evidence for the suspected condition is found and no treatment is currently required. The fact that the patient may be scheduled for continuing observation in the office/clinic setting following discharge does not limit the use of this category.

2.9 Original Treatment Plan Not Carried Out

Sequence as the principal diagnosis the condition which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

2.10 Residual Condition or Nature of Late Effect

The residual condition or nature of the late effect is sequenced first, followed by the late effect code for the cause of the residual condition, except in a few instances where the Alphabetic Index or Tabular List directs otherwise.

2.11 Multiple Burns

Sequence first the code that reflects the highest degree of burn when more than one burn is present (see also Burns guideline 8.3).

2.12 Multiple Injuries

When multiple injuries exist, the code for the most severe injury as determined by the attending physician is sequenced first.

2.13 Neoplasms

A. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis, except when the purpose of the encounter or hospital admission is for radiotherapy session(s), V58.0, or for chemotherapy session(s), V58.1, in which instance the malignancy is coded and sequenced second.

B. When a patient is admitted for the purpose of radiotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal diagnosis is Encounter for radiotherapy, V58.0, or Encounter for chemotherapy, V58.1.

C. When an episode of inpatient care involves surgical removal of a primary site or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the principal diagnosis, using codes in the 140–198 series or where appropriate in the 200–203 series.

D. When the reason for admission is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal diagnosis, even though chemotherapy or radiotherapy is administered.

E. When the primary malignancy has been previously excised or eradicated from its site and there is not adjunct treatment directed to that site and no evidence of any remaining malignancy at the primary site, use the appropriate code from the V10 series to indicate the former site of primary malignancy. Any mention of extension, invasion, or metastasis to a nearby structure or organ or to a distant site is coded as a secondary malignant neoplasm to that site and may be the principal diagnosis in the absence of the primary site.

F. When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

G. Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

H. Coding and sequencing of complications associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:

- When admission is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the anemia is designated at the principal diagnosis and is followed by the appropriate code(s) for the malignancy.
- When the admission is for management of an anemia associated with chemotherapy or radiotherapy and the only treatment is for the anemia, the

anemia is designated as the principal diagnosis followed by the appropriate code(s) for the malignancy.

- When the admission is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is designated as the principal diagnosis, followed by the code(s) for the malignancy.
- When the admission is for treatment of a complication resulting from a surgical procedure performed for the treatment of an intestinal malignancy, designate the complication as the principal diagnosis if treatment is directed at resolving the complication.

2.14 Poisoning

When coding a poisoning or reaction to the improper use of a medication (for example, wrong dose, wrong substance, or wrong route of administration) the poisoning code is sequenced first, followed by a code for the manifestation. If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code.

2.15 Complications of Surgery and Other Medical Care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996–999 series, an additional code for the specific complication may be assigned.

2.16 Complication of Pregnancy

When a patient is admitted because of a condition that is either a complication pregnancy or that is complicating the pregnancy, the code for the obstetric complication is the principal diagnosis. An additional code may be assigned as needed to provide specificity.

3. Reporting Other (Additional) Diagnoses

A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

These guidelines have been developed and approved by the Cooperating Parties to assure both the physician and the coder in identifying those diagnoses that are to be reported in addition to the principal diagnosis. Hospitals may record other diagnoses as needed for internal data use.

The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, *Federal Register* (Vol. 50, No. 147), pp. 31038–40.

The UHDDS item #11-b defines Other Diagnoses as “all conditions that exist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

General Rule

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring at least one of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction.

The listing of the diagnoses on the attestation statement is the responsibility of the attending physician.

3.1 Previous Conditions

If the physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some physicians include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (V10–V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

3.2 Diagnoses Not Listed in the Final Diagnostic Statement

When the physician has documented what appears to be a current diagnosis in the body of the record, but has not included the diagnosis in the final diagnostic statement, the physician should be asked whether the diagnosis should be added.

3.3 Conditions That Are an Integral Part of a Disease Process

Conditions that are integral to the disease process should not be assigned as additional codes.

3.4 Conditions That Are Not an Integral Part of a Disease Process

Additional conditions that may not be associated routinely with a disease process should be coded when present.

3.5 Abnormal Findings

Abnormal findings (from laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.

4. Hypertension

4.1 Hypertension, Essential, or NOS

Assign hypertension (arterial) (essential) (primary) (systemic) (NOS) to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9). Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.

4.2 Hypertension with Heart Disease

Certain heart conditions (425.8, 428,429.0-429.3,429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use only the code from category 402.

The same heart conditions (425.8,428, 429.0–429.3, 429.8, 429.9) with hypertension, but without a stated casual relationship, are coded separately. Sequence according to the circumstances of the admission.

4.3 Hypertensive Renal Disease with Chronic Renal Failure

Assign codes from category 403, Hypertensive renal disease, when conditions classified to categories 585–587 are present. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies renal failure with hypertension as hypertensive renal disease.

4.4 Hypertensive Heart and Renal Disease

Assign codes from combination category 404, Hypertensive heart and renal disease, when both hypertensive renal disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the renal disease, whether or not the condition is so designated.

4.5 Hypertensive Cerebrovascular Disease

First assign codes from 430–438, Cerebrovascular disease, then the appropriate hypertension code from categories 401–405.

4.6 Hypertensive Retinopathy

Two codes are necessary to identify the condition. First assign the code from subcategory 362.11, Hypertensive retinopathy, then the appropriate code from categories 401–405 to indicate the type of hypertension.

4.7 Hypertension, Secondary

Two codes are required: one to identify the underlying condition and one from category 405 to identify the hypertension. Sequencing of codes is determined by the reason for admission to the hospital.

4.8 Hypertension, Transient

Assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code 642.3x for transient hypertension of pregnancy.

4.9 Hypertension, Controlled

Assign appropriate code from categories 401–405. This diagnostic statement usually refers to an existing state of hypertension under control by therapy.

4.10 Hypertension, Uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories 401–405 to designate the stage and type of hypertension. Code to the type of hypertension.

4.11 Elevated Blood Pressure

For a statement of elevated blood pressure without further specificity, assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, rather than a code from category 401.

5. Obstetrics

These guidelines have been developed and approved by the Cooperating Parties in conjunction with the Editorial Advisory Board of Coding Clinic and the American College of Obstetricians and Gynecologists, to assist the coder in coding and reporting obstetric cases. Where feasible, previously published advice has been incorporated. Some advice in these new guidelines may supersede previous advice. The guidelines are provided for reporting purposes. Healthcare facilities may record additional diagnoses as needed for internal data needs.

5.1 General Rules

A. Obstetric cases require codes from chapter 11, codes in the range 630–677, Complications of pregnancy, childbirth, and the puerperium. Should the physician document that the pregnancy is incidental to the encounter then code V22.2 should be used in place of any chapter 11 codes. It is the physician's responsibility to state that the condition being treated is not affecting the pregnancy.

B. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions.

C. Chapter 11 codes are to be used only on the maternal record, never on the record of the newborn.

D. An outcome of delivery code, V27.0–V27.9, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

5.2 Selection of Principal Diagnosis

A. The circumstances of the encounter govern the selection of the principal diagnosis.

B. In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy that necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

C. When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean deliveries, the principal diagnosis should correspond to the reason the cesarean was performed, unless the reason for admission was unrelated to the condition resulting in the cesarean delivery.

D. For routine prenatal visits when no complications are present codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, should be used as principal diagnoses. These codes should not be used in conjunction with chapter 11 codes.

E. For prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the principal diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes if appropriate. A thorough review of any pertinent Excludes Note is necessary to be certain that these V codes are being used properly.

5.3 Chapter 11 Fifth Digits

A. Categories 640–648, 651–676 have required fifth digits that indicate whether the encounter is antepartum or postpartum, and whether a delivery has also occurred.

B. The fifth-digits which are appropriate for each code number are listed in brackets under each code. The fifth digits on each code should all be consistent with each

other. That is, should a delivery occur, all of the fifth digits should indicate the delivery.

5.4 Fetal Conditions Affecting the Management of the Mother

Codes from category 655, Known or suspected fetal abnormality affecting management of the mother, and category 656, Other fetal and placental problems affecting the management of the mother, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, that is, by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

5.5 Normal Delivery, 650

A. Code 650 is for use in cases when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode.

B. Code 650 may be used if the patient had a complication at some point during her pregnancy but the complication is not present at the time of the admission for delivery.

C. Code 650 is always a principal diagnosis. It is not to be used if any other code from chapter 11 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code 650 if they are not related to or are in any way complicating the pregnancy.

D. Code V27.0, Single liveborn, is the only outcome of delivery code appropriate for use with 650.

5.6 Procedure Codes

A. In cases of cesarean delivery, the selection of the principal diagnosis should correspond to the reason the cesarean delivery was performed unless the reason for admission was unrelated to the condition resulting in the cesarean delivery.

B. A delivery procedure code should not be used for a woman who has delivered prior to admission to the hospital. Any postpartum repairs should be coded.

5.7 The Postpartum Period

A. The postpartum period begins immediately after delivery and continues for six weeks following delivery.

B. A postpartum complication is any complication occurring within the six-week period.

C. Chapter 11 codes may also be used to describe pregnancy-related complications after the six week period should the physician document that a condition is pregnancy related.

D. Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of 2. Subsequent admissions for postpartum complications should identified with a fifth digit of 4.

E. When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code V24.0, Postpartum care and examination immediately after delivery, should be assigned as the principal diagnosis.

5.8 Abortions

A. Fifth digits are required for abortion categories 634–637. Fifth-digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus. Fifth-digit 2, complete, indicates that all products of conception have been expelled from the uterus prior to the episode of care.

B. A code from categories 640–648 and 651–657 may be used as additional codes with an abortion code to indicate the complication leading to the abortion. Fifth-digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply. Codes from the 660-669 series are not to be used for complications of abortion.

C. Code 639 is to be used for all complications following abortion. Code 639 cannot be assigned with codes from categories 634–638.

D. Abortion with Liveborn Fetus: When an attempted termination of pregnancy results m a liveborn fetus, assign code 644.21, Early onset of delivery, with an appropriate code from category V27, Outcome of delivery. The procedure code for the attempted termination of pregnancy should also be assigned.

E. Retained Products of Conception Following an Abortion: Subsequent admissions for retained products of conception following a spontaneous or legally induced abortion are assigned the appropriate code from category 634, Spontaneous abortion, or legally induced abortion, with a fifth digit of 1 (incomplete). This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

5.9 Code 677, Late Effect of Complication of Pregnancy, Childbirth, and the Puerperium

A. Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

B. This code may be used at any time after the initial postpartum period.

C. This code, like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

6. Newborn Guidelines

Definition

The newborn period is defined as beginning at birth and lasting through the twenty-eighth day following birth.

The following guidelines are provided for reporting purposes. Hospitals may record other diagnoses as needed for internal data use.

General Rule

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring
- Future healthcare needs

Note: The newborn guidelines listed above are the same as the general coding guidelines for "other diagnoses," except for the final bullet regarding implications for future healthcare needs. Whether or not a condition is clinically significant can only be determined by the physician.

6.1 Use of Codes V30–V39

When coding the birth of an infant, assign a code from categories V30 through V39, according to the type of birth. A code from this series is assigned as a principal diagnosis, and assigned only once to a newborn at the time of birth.

6.2 Newborn Transfers

If the newborn is transferred to another institution, the V30 series is not used.

6.3 Use of Category V29

A. Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.

B. A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code. It may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. It is for use only for healthy newborns and infants in whom no condition after study is found to be present.

6.4 Maternal Causes of Perinatal Morbidity

Codes from categories 760–763, Maternal causes of perinatal morbidity and mortality, are assigned only when the maternal condition has actually affected the fetus or newborn. The fact that the mother has an associated medical condition or experiences some complication of pregnancy, labor, or delivery does not justify the routine assignment of codes from these categories to the newborn record.

6.5 Congenital Anomalies

Assign an appropriate code from categories 740-759, Congenital anomalies, when a specific abnormality is diagnosed for an infant. Such abnormalities may occur as a set of symptoms or multiple malformations. A code should be assigned for each presenting manifestation of the syndrome if the syndrome is not specifically indexed in ICD-9-CM.

6.6 Coding of Other (Additional) Diagnoses

A. Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

B. Assign codes for conditions that have been specified by the physician as having implications for future healthcare needs. This guideline should not be used for adult patients.

C. Assign a code for newborn conditions originating in the perinatal period (categories 760–779), as well as complications arising during the current episode of care classified in other chapters, only if the diagnoses have been documented by the responsible physician at the time of transfer or discharge as having affected the fetus or newborn.

D. Insignificant conditions or signs or symptoms that resolve without treatment are not coded.

6.7 Prematurity and Fetal Growth Retardation

Codes from categories 764 and 765 should not be assigned based solely on recorded birthweight or estimated gestational age, but upon the attending physician's clinical assessment of maturity of the infant. Since physicians may utilize different criteria in determining prematurity, do not code the diagnosis of prematurity unless the physician documents this condition.

7. Septicemia and Septic Shock

When the diagnosis of septicemia with shock or the diagnosis of general sepsis with septic shock is documented, code and list the septicemia first and report the septic shock code as a secondary condition. The septicemia code assignment should identify the type of bacteria if it is known.

Sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630–639).

Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia in patients with clinical evidence of the condition.

8. Trauma

8.1 Coding for Multiple Injuries

When coding multiple injuries such as fracture of tibia and fibula, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available.

A. The code for the most serious injury, as determined by the physician, is sequenced first.

B. Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

C. When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950–957, Injury to nerves and spinal cord, and/or 900–904, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

8.2 Coding for Multiple Fractures

The principle of multiple coding of injuries should be followed in coding multiple fractures. Multiple fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800–829 and the level of detail furnished by health record content. Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level. More specific guidelines are as follows:

A. Multiple fractures of same limb classifiable to the same three-digit or four-digit category are coded to that category.

B. Multiple unilateral or bilateral fractures of same bone(s) but classified to different fourth-digit subdivisions (bone part) within the same three-digit category are coded individually by site.

C. Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth-digit level other than open and closed type of fractures.

D. Multiple fractures are sequenced in accordance with the severity of the fracture and the physician should be asked to list the fracture diagnoses in the order of severity.

8.3 Current Burns and Encounters for Late Effects of Burns

Current burns (940–948) are classified by depth, extent, and, if desired, by agent (E code). By depth burns are classified as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

A. All burns are coded with the highest degree of burn sequenced first.

B. Classify bums of the same local site [three-digit category level, (940–947)] but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

C. Non-healing burns are coded as acute burns. Necrosis of burned skin should be coded as a non-healed burn.

D. Assign code 958.3, Posttraumatic wound infection, not elsewhere classified, as an additional code for any documented infected burn site.

E. When coding multiple burns, assign separate codes for each burn site. Category 946, Burns of multiple specified sites, should only be used if the location of the burns are not documented.

Category 949, Burn, unspecified, is extremely vague and should rarely be used.

F. Assign codes from category 948, Burns classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category 948 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface. In assigning a code from category 948:

- Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degree)
- Fifth digits are assigned to identify the percentage of body surface involved in third-degree burn
- Fifth-digit zero (0) is assigned when less than 10 percent or when no body surface is involved in a third-degree burn

Category 948 is based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Physicians may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomen that involve burns.

G. Encounters for the treatment of the late effects of burns (that is, scars or joint contractures) should be coded to the residual condition (sequelae) followed by the appropriate late effect code (906.5–906.9). A late effect E code may also be used, if desired.

H. When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record.

8.4 Debridement of Wound, Infection, or Burn

A. For coding purposes, excisional debridement, 86.22, is assigned only when the procedure is performed by a physician.

B. For coding purposes, nonexcisional debridement performed by the physician or nonphysician healthcare professional is assigned to 86.28. Any "excisional" type procedure performed by a nonphysician is assigned to 86.28.

9. Adverse Effects and Poisoning

The properties of certain drugs, medicinal and biological substances, or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows.

9.1 Adverse Effect

When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930–E949 series.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability.

Codes from the E930–E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, when correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930–E949 series.

9.2 Poisoning

When poisoning occurs as a result of an error made in drug prescription or in the administration of the drug by physician, nurse, patient, or other person, use the appropriate code from the 960–979 series. If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning (960–979 series). If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

10. Human Immunodeficiency Virus (HIV) Infections

10.1 Code Only Confirmed Cases of HIV Infection/Illness

This is an exception to guideline 1.8 which states, "If the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' likely,' 'questionable,' 'possible,' or 'still to be ruled out,' code the condition as if it existed or was established..."

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the physician's diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

10.2 Selection of HIV Code

042 Human Immunodeficiency Virus [HIV] Disease: Patients with an HIV-related illness should be coded to 042, Human Immunodeficiency Virus [HIV] Disease.

V08 Asymptomatic Human Immunodeficiency Virus [HIV] Infection: Patients with physician-documented asymptomatic HIV infections who have never had an HIV-related illness should be coded to V08, Asymptomatic Human Immunodeficiency Virus [HIV] Infection.

795.71 Nonspecific Serologic Evidence of Human Immunodeficiency Virus [HIV]: Code 795.71, Nonspecific serologic evidence of human immunodeficiency virus [HIV], should be used for patients (including infants) with inconclusive HIV test results.

10.3 Previously Diagnosed HIV-Related Illness

Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient had developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

10.4 Sequencing

The sequencing of diagnoses for patients with HIV-related illnesses follows guideline two for selection of principal diagnosis. That is, the circumstances of admission govern the selection of principal diagnosis, "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Patients who are admitted for an HIV-related illness should be assigned a minimum of two codes: first assign code 042 to identify the HIV disease and then sequence additional codes to identify the other diagnoses. If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (for example, the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.

Whether the patient is newly diagnosed, has had previous admissions for HIV conditions, or has expired is irrelevant to the sequencing decision.

10.5 HIV Infection in Pregnancy, Childbirth, and the Puerperium

During pregnancy, childbirth, or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.8X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth, or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). This is an exception to the sequencing rule found in 10.4 above.

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of 647.8X and V08.

10.6 Asymptomatic HIV Infection

V08 Asymptomatic human immunodeficiency virus [HIV] infection, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

10.7 Inconclusive Laboratory Test for HIV

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness may be assigned code 795.71. Inconclusive serologic test for Human Immunodeficiency Virus [HIV].

10.8 Testing for HIV

If the patient is asymptomatic but wishes to know his/her HIV status, use code V73.89, Screening for other specified viral disease. Use code V69.8, Other problems related to lifestyle, as a secondary code if an asymptomatic patient is in a known high-risk group for HIV. Should a patient with signs or symptoms of illness or a confirmed HIV-related diagnosis be tested for HIV, code the signs and symptoms or the diagnosis. An additional counseling code, V65.44, may be used if counseling is provided during the encounter for the test.

When the patient returns to be informed of his/her HIV test results, use code V65.44, HIV counseling, if the results of the test are negative. If the results are positive but the patient is asymptomatic, use code V08, Asymptomatic HIV infection. If the results are positive and the patient is symptomatic, use code 042, HIV infection, with codes for the HIV-related symptoms or diagnosis. The HIV counseling code may also be used if counseling is provided for patients with positive test results.

11. Guidelines for Coding External Causes of Injuries, Poisonings, and Adverse Effects of Drugs (E Codes)

These guidelines are provided for those who are currently collecting E codes so there will be standardization in the process. If your institution plans to begin collecting E codes, these guidelines are to be applied. The use of E codes are supplemental to the application of basic ICD-9-CM codes. E codes are never to be recorded as principal diagnosis (first listed in the outpatient setting) and are not required for reporting to the Healthcare Financing Administration.

Injuries are a major cause of mortality, morbidity, and disability. In the United States, the care of patients who suffer intentional and unintentional injuries and poisonings contributes significantly to the increase in medical care costs. External causes of injury and poisoning codes (E codes) are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury or poisoning happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred. These are some major categories of E codes:

- Transport accidents
- Poisoning and adverse effects of drugs, medicinal substances, and biologicals
- Accidental falls
- Accidents caused by fire and flames
- Accidents due to natural and environmental factors
- Late effects of accidents, assaults, or self-injury
- Assaults or purposely inflicted injury
- Suicide or self-inflicted injury

These guidelines apply for the coding and collection of E codes from records in hospitals, outpatient clinics, emergency departments, other ambulatory care settings, and physician offices except when other specific guidelines apply. (See Reporting Diagnostic Guidelines for Hospital-based Outpatient Services/Reporting Requirements for Physician Billing.)

11.1 General E Code Coding Guidelines

A. An E code may be used with any code in the range of 001–V82.9 which indicates an injury, poisoning, or adverse effect due to an external cause.

B. Assign the appropriate E code for all initial treatments of an injury, poisoning, or adverse effect of drugs.

C. Use a late effect E code for subsequent visits when a late effect of the initial injury or poisoning is being treated. There is no late effect E code for adverse effects of drugs.

D. Use the full range of E codes to completely describe the cause, the intent, and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.

E. Assign as many E codes as necessary to fully explain each cause. If only one E code can be recorded, assign the E code most related to the principal diagnosis.

F. The selection of the appropriate E code is guided by the Index to External Causes which is located after the alphabetical index to diseases and by Inclusion and Exclusion notes in the Tabular List.

G. An E code can never be a principal (first listed) diagnosis.

11.2 Place of Occurrence Guideline

Use an additional code from category E849 to indicate the Place of Occurrence for injuries and poisonings. The Place of Occurrence describes the place where the event occurred and not the patient's activity at the time of the event.

Do not use E849.9 if the place of occurrence is not stated.

11.3 Poisonings and Adverse Effects of Drugs, Medicinal, and Biological Substances Guidelines

A. Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

B. Use as many codes as necessary to describe completely all drugs, medicinal, or biological substances.

C. If the same E code would describe the causative agent for more than one adverse reaction, assign the code only once.

D. If two or more drugs, medicinal, or biological substances are reported, code each individually unless the combination code is listed in the Table of Drugs and Chemicals. In that case, assign the E code for the combination.

E. When a reaction results from the interaction of a drug(s) and alcohol, use poisoning codes and E codes for both.

F. If the reporting format limits the number of E codes that can be used in reporting clinical data, code the one most related to the principal diagnosis. Include at least one from each category (cause, intent, place) if possible.

If there are different fourth-digit codes in the same three-digit category, use the code for "Other specified" of that category. If there is no "Other specified" code in that category, use the appropriate "Unspecified" code in that category.

If the codes are in different three digit categories, assign the appropriate E code for other multiple drugs and medicinal substances.

11.4 Multiple Cause E Code Coding Guidelines

If two or more events cause separate injuries, an E code should be assigned for each cause. The first-listed E code will be selected in the following order:

- E codes for child and adult abuse take priority over all other E codes (See 11.5, Child and Adult Abuse Guideline)
- E codes for cataclysmic events take priority over all other E codes except child and adult abuse
- E codes for transport accidents take priority over all other E codes except cataclysmic events and child and adult abuse

The first-list E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

11.5 Child and Adult Abuse Guideline

A. When the cause of an injury or neglect is intentional child or adult abuse, the first listed E code should be assigned from categories E960–E968, Homicide and injury purposely inflicted by other persons, (except category E967). An E code from category E967, Child and adult battering and other maltreatment, should be added as an additional code to identify the perpetrator, if known.

B. In cases of neglect when the intent is determined to be accidental E code E904.0, Abandonment or neglect of infant and helpless person, should be the first listed E code.

11.6 Unknown or Suspected Intent Guideline

A. If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown or unspecified, code the intent as undetermined E980–E989.

B. If the intent (accident, self-harm, or assault) of the cause of an injury or poisoning is questionable, probable, or suspected, code the intent as undetermined E980-E989.

11.7 Undetermined Cause

When the intent of an injury or poisoning is known, but the cause is unknown, use codes: E928.9, Unspecified accident, E958.9, Suicide and self-inflicted injury by unspecified means, and E968.9, Assault by unspecified means.

These E codes should rarely be used as the documentation in the medical record, in both the inpatient and outpatient settings, should normally provide sufficient detail to determine the cause of the injury.

11.8 Late Effects of External Cause Guidelines

A. Late effect E codes exist for injuries and poisonings but not for adverse effects of drugs, misadventures, and surgical complications.

B. A late effect E code (E929, E959, E969, E977, E989, or E999) should be used with any report of a late effect or sequela resulting from a previous injury or poisoning (905–909).

C. A late effect E code should never be used with a related current nature of injury code.

11.9 Misadventures and Complications of Care Guidelines

A. Assign a code in the range of E870–E876 if misadventures are stated by the physician.

B. Assign a code in the range of E878–E879 if the physician attributes an abnormal reaction or later complication to a surgical or medical procedure, but does not mention misadventure at the time of the procedure as the cause of the reaction.

12. Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office)

These revised coding guidelines for outpatient diagnoses have been approved for use by hospitals/physicians in coding and reporting hospital-based outpatient services and physician office visits. These guidelines were revised October 1, 1995, and replace the official guidelines on the October 1, 1994, CD-ROM.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM Tabular List (code numbers and titles), can be found in the section at the beginning of the ICD-9-CM on Conventions Used in the Tabular List. Information about the correct sequence to use in finding a code is described in the Introduction to the Alphabetic Index of ICD-9-CM.

The terms *encounter* and *visit* are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Coding guidelines for outpatient and physician reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing the following:

- The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, general hospitals
- Coding guidelines for inconclusive diagnoses (for example, probable, suspected, and rule out) were developed for inpatient reporting and do not apply to outpatients
- Diagnoses may take two or more visits before the diagnosis is confirmed

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List, as this will lead to coding errors.

Basic Coding Guidelines for Outpatient Services

A. The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

B. For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology that includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

C. The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (for example, infectious and parasitic diseases, neoplasms, and symptoms, signs, and ill-defined conditions).

D. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been diagnosed (or confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined Conditions (codes 780.0–799.9), contains many, but not all, codes for symptoms.

E. ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0–V82.9) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

F. ICD-9-CM is composed of codes with either three, four, or five digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity.

   A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.

G. List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.

H. Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis." Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. This is contrary to the coding practices used by hospitals and medical record departments for coding the diagnosis of hospital inpatients.

I. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

J. Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10–V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

L. For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that patients receiving chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.*

N. For patient's receiving preoperative evaluations only, sequence a code from category V72.8, Other specified examinations, to describe the preop consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the preop evaluation.

O. For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

*There is no point M in the original Basic Coding Guidelines for Outpatient Services.

Introduction

Some of the articles in the following section, such as "Growing Demand for Accurate Coded Data in New Healthcare Deliver Era," "Total Standardization of Health Information," and "The Quest for Quality and Comparability in the National Healthcare Database: Announcing A Payer's Guide to Health Care Data Quality and Integrity," were originally published a few years ago, but are still valid in today's healthcare environment. Many of the issues in the articles still exist and will continue to exist as long as there is not consistent adherence to the official coding rules and guidelines. Discrepancies in healthcare data will continue until all payers require standardization of reporting using the official coding guidelines. Variable reporting requirements invalidate aggregate healthcare data used to characterize groups of patients and obscure underlying causes and comorbidities related to severity of illness and injury. The following articles are presented to promote consistent reporting of healthcare data by following uniform rules and guidelines.